

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

02 -- 0 1 2

2. STATE:

MAINE

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE(S)

10/01/02

5. TYPE OF PLAN MATERIAL (CHECK ONE):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:

a. FFY 03 \$ 20,000,000

b. FFY 04 \$ 20,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATT. 4.19D PP. 23,36-38,43,539. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): ATT. 4.19D
PP. 23,36-38,43,53, 53ASUBJECT OF AMENDMENT: ADD NF ASSESSMENT AS ALLOWABLE COST, REMOVE RETURN ON EQUITY FOR NONPROFIT
ADJUST THE TRIGGER FOR OCCUPANCY PENALTY, INCREASE PAYMENTS BASED ON A FACILITY'S MAINE CARE
UNREIMBURSED ALLOWABLE DIRECT CARE COSTS AND THE FACILITY'S SHARE OF STATEWIDE DIRECT CARE SPENDING

11. GOVERNOR'S REVIEW (Check One):

- ☐
- GOVERNOR'S OFFICE REPORTED NO COMMENT
-
- ☐
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
-
- ☐
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED
COMMISSIONER, DEPT. OF HUMAN SERVICES

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Kevin W. Concannon

14. TITLE:

Commissioner, Maine Department of Human Services

15. DATE SUBMITTED: DECEMBER 27, 2002

16. RETURN TO:

EUGENE GESSOW

Director, Bureau of Medical Services

#11 State House Station

442 CIVIC CENTER DRIVE

Augusta, ME 04333-0011

17. DATE RECEIVED:

19. EFFECTIVE DATE OF APPROVED MATERIAL:

21. TYPED NAME:

CHARLENE BROWN

23. REMARKS:

- 44.1.7 rental expenses,
- 44.1.8 amortization of finance costs,
- 44.1.9 amortization of start-up costs and organizational costs,
- 44.1.10 motor vehicle insurance,
- 44.1.11 facility's liability insurance, including malpractice costs and workers compensation,
- 44.1.12 administrator in training,
- 44.1.13 water & sewer fees necessary for the initial connection to a sewer system/water system,
- 44.1.14 portion of the acquisition cost for the rights to a nursing facility license,
- 44.1.15 Nursing facility health care provider tax.

See the explanations in Sections 44.2 - 44.12 for a more complete description of allowable costs in each of these cost centers.

44.2 Principle. An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be:

44.2.1 Depreciation. Allowance for Depreciation Based on Asset Costs.

44.2.2 Identified and recorded in the provider's accounting records.

44.2.3 Based on historical cost and prorated over the estimated useful life of the asset using the straight-line method.

44.2.4 The total historical cost of a building constructed or purchased becomes the basis for the straight-line depreciation method. Component depreciation is not allowed except on those items listed below with their minimum useful lives:

Electric Components	20 years
Plumbing and Heating Components	25 years
Central Air Conditioning Unit	15 years
Elevator	20 years
Escalator	20 years
Central Vacuum Cleaning System	15 years
Generator	20 years

44.22 Any provider using the component depreciation method that has been audited and accepted for cost reporting purposes prior to April 1, 1980, will be allowed to continue using this depreciation mechanism.

44.23 Where an asset that has been used or depreciated under the program is donated to a provider, or where a provider acquires such assets through testate or intestate distribution, (e.g., a widow inherits a nursing facility upon the death of her husband and becomes a newly certified provider;) the basis of

44.71.2 The wages and fringes paid to workers engaged in formal Modified or Light-Duty Early-Return-To-Work Programs are allowable costs only to the extent that they cause a nursing facility to exceed its staffing pattern. Rehabilitation eligibility assessments are a cost to a limit of \$300.00 per indemnity claimant. (Rehabilitation services provided to eligible injured workers are to be paid for by their employers insurer.)

44.8 Administrator in Training. The reasonable salary of an administrator in training will be accepted as an allowable cost for a period of six months provided there is a set policy, in writing, stating the training program to be followed, position to be filled, and provided that this individual obtain an administrator's license and serve as an administrator of a facility in the State of Maine. Prior approval in writing, from the Department, must be issued in advance of the date of any salary paid to an administrator in training. A request for prior approval must be received by the Department at least two (2) weeks prior to the desired effective start date of the administrator in training program. Failure to receive approval from the Department for the Administrator in Training salary will deem that salary an unallowable cost at time of audit. Failure to become an administrator within one year following completion of the examination to become a licensed administrator will result in the Department of Human Services recovering 100% of the amount allowed of the administrator in training. If the administrator in training discontinues the training program for any reason or fails to take the required examination to become a licensed administrator, 100% of the amount allowed will be recovered by the Department.

44.9 Acquisition Costs. Fifty percent of the acquisition cost of the rights to a nursing facility license shall be approved as a fixed cost in those situations where the purchaser acquires the entire existing nursing facility license of a provider and delicensures all or a significant portion (at least 50%) of the beds associated with that license. This amount will be amortized over a ten (10) year period, beginning with the subsequent fiscal year after completion of the acquisition. This acquisition cost will not include any fees (eg: accounting, legal) associated with the acquisition.

44.10 Occupancy Adjustment.

Facilities With Greater Than 60 Beds. To the extent that fixed costs are allowable, such cost will be adjusted for providers whose annual level of occupancy is less than ninety percent (90%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of ninety percent (90%). For all new providers coming into the program, the 90% occupancy adjustment will not apply for the first 90 days of operation. It will, however, apply to the remaining months of their initial operating period. The occupancy rate adjustment will be applied to fixed costs and shall be cost settled at the time of audit.

Facilities With 60 or Fewer Beds. To the extent that fixed costs are allowable, such cost will be adjusted for providers whose annual level of occupancy is less than eighty-five percent (85%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of eighty-five percent (85%). For all new providers of sixty (60) or fewer beds coming into the program, the 85% occupancy adjustment will not apply for the first 90 days of operation. It

will, however, apply to the remaining months of their initial operating period. The occupancy rate adjustment will be applied to fixed costs and shall be cost settled at the time of audit.

44.11 Start Up Costs Applicability

Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first resident is admitted for treatment, or where the start-up costs apply only to nonrevenue-producing resident care functions or unallowable functions, to the time the areas are used for their intended purposes. Start-up costs are charged to operations. If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility will be accumulated in a single deferred charge account and will be amortized when the first resident is admitted for treatment. If a provider intends to prepare portions of its facility on a piecemeal basis (e.g., preparation of a floor or wing of a provider's facility is delayed), start-up costs would be capitalized and amortized separately for the portion(s) of the provider's facility prepared during different time periods. Moreover, if a provider expands its facility by constructing or purchasing additional buildings or wings, start-up costs should be capitalized and amortized separately for these areas.

Start-up costs that are incurred immediately before a provider enters the program and that are determined to be immaterial by the Department need not be capitalized, but rather will be charges to operations in the first cost reporting period. In the case where a provider incurs start-up costs while in the program and these costs are determined to be immaterial by the Department, these costs need not be capitalized, but will be charged to operations in the periods incurred.

For program reimbursement purposes, costs of the provider's facility and building equipment should be depreciated over the lives of these assets starting with the month the first resident is admitted for treatment, subject to the provider's method of determining depreciation in the year of acquisition or construction. Where portions of the provider's facility are prepared for resident care services after the initial start-up period, these asset costs applicable to each portion should be depreciated over the remaining lives of the applicable assets. If the portion of the facility is a resident care area, depreciation should start with the month the first resident is admitted for treatment. If the portion of the facility is a nonrevenue - producing resident care area or unallowable area, depreciation should begin when the area is opened for its intended purpose. Costs of major movable equipment, however, should be depreciated over the useful life or each item starting with the month the item is placed into operation.

Where a provider prepares all portions of its facility for resident care services at the same time and has capitalized start-up costs, the start-up costs must be amortized ratably over a period of 60 consecutive months beginning with the month in which the first resident is admitted for treatment.

Where a provider prorates portions of its facility for resident care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for resident care services during different periods of time.

44.12 Nursing Facility Health Care Provider Tax.

Nursing facilities subject to the Health Care Provider Tax defined in state law at 36 MRSA chapter 373 will have the tax treated as an allowable fixed cost. Only taxes actually collected by Maine Revenue Services will be considered allowable.

50 PUBLIC HEARING

The State of Maine will provide for public hearings as necessary in our State Plan, according to State procedures.

60 WAIVER

The failure of the Department to insist, in any one or more instances, upon the performance of any of the terms or conditions of these Principles, or to exercise any right under these principles, or to disapprove of any practice, accounting procedure, or item of account in any audit, shall not be construed as a waiver of future performance of the right. The obligation of the Provider with respect to future performance shall continue, and the Department shall not be stopped from requiring such future performance.

70 SPECIAL SERVICE ALLOWANCE

70.1 Principle. A special ancillary service is to be distinguished from a service generally provided in the nursing facility.

70.1.1 A special ancillary service is that of an individual nature required in the case of a specific resident. This type of service is limited to professional services such as physical therapy, occupational therapy, and speech and hearing services. Special services of this nature must be billed monthly to the Department as separate items required for the care of individual recipients.

71 OMNIBUS RECONCILIATION ACT OF 1987 (OBRA 87)

OBRA 1987 has eliminated the distinction between ICFs and SNFs and the method of payment by such classifications. The statute provides for only one type of nursing facility. All nursing homes are now classified as a "nursing facility" with a single payment methodology.

80 ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE

80.1 Principle. For services provided on or after July 1, 2000, the Department will establish a prospective per diem rate to be paid to each facility until the end of its fiscal year. Each nursing facility's cost components for the fiscal year ending in 1998, as determined from the audited cost report (or as filed cost report) will be the basis for the base year computations (subject to upper limits). Allowable costs are separated into three components - direct, routine and fixed costs.

The base year direct and routine cost component costs will be trended forward using the guidelines describe in Section 91.

80.3.3.6 Each facility's case mix direct care rate shall be the lesser of the limit in Section 80.3.3.5. or the facility's base year case mix adjusted cost per day.

80.3.4 Quarterly Calculation of the Direct Care Component

The Bureau of Medical Services shall compute the direct resident care cost component for each facility on a quarterly basis.

80.3.4.1 Calculation of the quarterly case mix index.

The Bureau of Medical Services shall compute each facility's quarterly case mix index for the rate period as follows:

For each facility the number of Medicaid residents in each case mix classification group shall be determined from the most recent MDS on all Medicaid residents in the facility as of the 15th day of the prior quarter (e.g. For a October 1 rate, the facility's case mix index would be computed using the most recent assessments of Medicaid residents with an assessment date of June 15.)

For each facility, the Bureau will multiply the number of Medicaid residents in each case mix classification group including those in the unclassified group by the case mix weight for the relevant classification group. The sum of these products divided by the total number of Medicaid residents equals the facility's quarterly case mix index. The roster sent to the nursing facility for confirmation of residents in the nursing facility is relied upon by the Department in determining the residents in the nursing facility. It is the nursing facilities responsibility to check the roster and make corrections within one week of receiving the roster and submit such corrections to the Department or it's designee. MDS Corrections for assessments used in the calculation of a facility's quarterly case mix index will not be considered in the calculation of the index when received in the MDS CORE system after the calculation of the rate by the Bureau of Medical Services.

For purposes of this section, resident assessments that are incomplete due to the death, discharge, or hospital admission of the resident during the time frame in which the assessment must be completed will not be included in the unclassified group or used to compute the case mix index. (Note: For Medicaid residents, the facility would be paid the facility rate for the number of days the resident is at the facility.)

80.3.4.2 Direct care rate per day

The direct care rate per day shall be computed by multiplying the allowable base year case mix adjusted cost per day by the applicable case mix index.

80.3.4.3 The direct cost, as defined in Section 41, shall be determined by adjusting the allowable necessary and reasonable direct care costs (subject to the limitations cited in Section 41) from the base year by the inflationary factor defined in Section 91, for dates of services on or after July 1, 2000 and for 50% of any allowable unreimbursed direct care costs for dates of services during provider fiscal years ending in calendar year 2001.

Region III - Penobscot County, Piscataquis County, Waldo County, Hancock County, and Washington County.

Region IV - Aroostook County

93 DAYS WAITING PLACEMENT

Reimbursement to nursing facilities for days waiting placement are governed by the regulations specified in the Principles of Reimbursement for Residential Care Facilities.

101 SUPPLEMENTAL PAYMENT TO NURSING FACILITIES

101.1 Funds have been appropriated for the purpose of assisting the nursing facilities in recruiting and retaining staff. Funds will be disbursed to nursing facilities as a supplemental payment that is not included as part of the per diem rate.

101.2 The supplemental payment is based on the facility's calendar year 2001 case mix adjusted direct care component multiplied by the facility's total Medicaid days, which results in a facility specific case mix adjusted Medicaid direct care cost. The facility's percentage of the total amount of supplemental payment available equals the facility specific case mix adjusted Medicaid direct care cost divided by the total Medicaid direct care cost for all nursing facilities. The amount of the supplemental allowance is calculated by multiplying the total amount available for all nursing facilities by this facility specific percentage.

120 EXTRAORDINARY CIRCUMSTANCE ALLOWANCE

Facilities which experience unforeseen and uncontrollable events during a year which result in unforeseen or uncontrollable increases in expenses may request an adjustment to a prospective rate in the form of an extraordinary circumstance allowance. Extraordinary circumstances include, but are not limited to:

- * events of a catastrophic nature (fire, flood, etc.)
- * unforeseen increase in minimum wage, Social Security, or employee retirement contribution expenses in lieu of social security expenses
- * changes in the number of licensed beds
- * changes in licensure or accreditation requirements

If the Department concludes that an extraordinary circumstance existed, an adjustment will be made by the Department in the form of a supplemental allowance.

The Department will determine from the nature of the extraordinary circumstance whether it would have a continuing impact and therefore whether the allowance should be included in the computation of the base rate for the succeeding year.

121 CERTIFICATE OF NEED EXTRAORDINARY CIRCUMSTANCE ALLOWANCE

121.1 Based on findings made by the Commissioner of the Department of Human Services (hereinafter, the Commissioner), the Department may approve extraordinary routine and fixed costs in excess of the provider's approved Certificate of Need (CON) that are within the upper limits established by the Department for the routine component, when all of the following conditions are met:

121.1(a) Costs would ordinarily be allowable under Federal Regulations and these Principles of Reimbursement;

121.1(b) Costs would have been allowable under the CON had a CON amendment been filed within the time constraints as outlined in the CON statutes and approved by the Department;

121.1(c) Approval is necessary in order for the Provider to obtain favorable refinancing, as determined by the Department;

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Tn. No.: 02-012
Supercedes
Tn. No.:

APR 3 2003
Approval Date: _____ Effective Date: 10/1/02